Exhibit I

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

CASE NO. 09-2051-MD-ALTONAGA

In re

DENTURE CREAM PRODUCTS LIABILITY LITIGATION.

_____/

This Document Relates to All Actions

CASE MANAGEMENT ORDER NO. 4 REGARDING PLAINTIFF FACT SHEET AND RELATED AUTHORIZATIONS (CMO 4)

THIS CAUSE came before the Court on the parties' Joint Notice of Filing Case Management Order No 4 Regarding Plaintiff Fact Sheet and Related Authorizations [D.E. 106], filed September 23, 2009. Being fully advised, it is

ORDERED AND ADJUDGED that:

PURPOSE AND SCOPE OF CMO 4

The purpose of this Order is to approve for use the form of the previously submitted Plaintiff Fact Sheet, and related Authorizations not previously submitted, to set forth procedures for service by Defendants of the Plaintiff Fact Sheet and related Authorizations, and to modify Case Management Order No. 3 — Initial Scheduling and Written Discovery (CMO 3) regarding the due date within which certain Plaintiffs are to serve completed Plaintiff Fact Sheets and executed Authorizations. This Order applies to all cases docketed in MDL-2051 at the time this Order is entered and to related cases later filed in, removed, or transferred to this Court. The "GSK Defendants" referenced in this Order include SmithKline Beecham Corporation d/b/a GlaxoSmithKline, GlaxoSmithKline Consumer Health Care L.L.C., GlaxoSmithKline Consumer

Healthcare, L.P. and Block Drug Company, Inc. The "P&G Defendants" referenced in this Order include The Procter & Gamble Manufacturing Company and The Procter & Gamble Distributing LLC.

APPROVAL OF PLAINTIFFS' FACT SHEET AND RELATED AUTHORIZATIONS

1. The form of the previously submitted Plaintiff Fact Sheet is set forth in the attached Exhibit A and is hereby approved for use.

2. The forms of the Authorizations for release of records accompanying Plaintiff Fact Sheet are set forth in the attached Exhibit B and are hereby approved for use.

DUE DATE FOR PLAINTIFFS' RESPONSES TO PLAINTIFF FACT SHEET AND EXECUTED AUTHORIZATIONS AND MODIFICATION TO CMO NO. 3

3. For cases already docketed in the MDL at the time CMO 3 was entered on September 3, 2009, the due date within which Plaintiffs are to serve completed Plaintiff Fact Sheets and executed Authorizations is governed by Section VI(A)(2) of CMO 3.

4. For all other cases, the due date within which Plaintiffs are to serve completed Plaintiff Fact Sheets and executed Authorizations shall be forty-five (45) days from the date of service by Defendants of Plaintiffs' Fact Sheet and related Authorizations, as set forth in paragraphs 6 below. Section VI(A)(2) of CMO 3 is modified as set forth in this paragraph. All other provisions of CMO 3 remain in effect. Service by Defendants as set forth in paragraph 6 below may be accomplished (a) electronically via email, (b) by facsimile, or (c) by certified mail, return receipt requested if only a physical address is available.

DEFENDANTS' SERVICE OF PLAINTIFF FACT SHEET ON CASE-SPECIFIC COUNSEL FOR PLAINTIFF

5. For cases already docketed in the MDL at the time CMO No 3 was entered on September

3, 2009, Defendants are not required to provide any additional service or notice to Plaintiffs' counsel of Plaintiff Fact Sheet or the related Authorizations. The due date within which Plaintiff must serve completed Plaintiff Fact Sheet and executed Authorizations is governed by Section VI(A)(2) of CMO 3.

6. For all other cases, whether filed outside the Southern District of Florida and subject to transfer to the MDL as a Tag-Along, or filed directly in the Southern District of Florida, the GSK Defendants or the P&G Defendants (as applicable) shall serve on Plaintiff's counsel in that case a copy of (a) Plaintiff Fact Sheet, (b) related Authorizations, (c) Case Management Order No 2. — Confidentiality Agreement and Protective Order (CMO 2); (d) CMO 3; and (e) CMO 4. The due date within which Plaintiff must serve completed Plaintiff Fact Sheet and executed Authorizations shall be forty-five (45) days from the date of service, as set forth in paragraph 4 above.

7. Service on Plaintiff's counsel as described in paragraph 6 above does not constitute waiver of service, waiver of the notice requirements of Section IV(A) of CMO 3, or an appearance by the GSK Defendants or the P&G Defendants in any case.

DONE AND ORDERED in Chambers at Miami, Florida, this 23rd day of September, 2009.

Cecilia M. Altonaga

CECILIA M. ALTONAGA
UNITED STATES DISTRICT JUDGE

cc: counsel of record

Exhibit A – Plaintiff Fact Sheet

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

Case No. 1:09-MD-02051-ALTONAGA

IN RE DENTURE CREAM PRODUCTS
LIABILITY LITIGATION -- MDL-2051,

This Document Relates To All Actions

THIS RELATES TO MDL DOCKET 2051

PLAINTIFF: _____
Name(s)

PLAINTIFF FACT SHEET

Please provide, to the best of your knowledge and ability, the following information for each individual on whose behalf a claim is being made. If you are completing this questionnaire in a representative capacity, please respond to the questions in sections I (A), I (B), and II through XIII with respect to the person by whom Denture Adhesive Cream was allegedly used ("Denture Adhesive Cream User" or "User"). In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. If you cannot recall or determine the exact date(s) requested, then please provide your best approximation. To the extent you recall details after you submit your fact sheet, you are obligated to supplement your fact sheet with the additional information. *Please attach as many additional sheets of paper as are necessary to fully and completely answer these questions*.

In filling out this form, please use the following definitions and instructions:

(1) "Health Care Provider" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, nursing, dietary, and any pharmacy, x-ray department, laboratory, physical therapist or physical therapy department, radiologist or radiology group, dermatologist, surgeon, x-ray department or facility, rehabilitation specialist or facility, physician, osteopath, homeopath, chiropractor, podiatrist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you. "Health Care Provider" as defined herein does not include a purely "consulting expert" (as interpreted and defined by governing rules, and subject to the provisions and limitations of the Federal Rules of Civil Procedure) who: (1) has been specifically retained by your counsel in this Lawsuit to evaluate or diagnose your medical and/or mental condition; *and* (2) has not, outside of this retained role, ever been involved in your evaluation, diagnosis, care and/or treatment.

(2) "Oral Health Care Provider" means any dentist, oral surgeon, endodontist, periodontist, prosthodontist, denturist, orthodontist, dental hygienist, other provider of dental or

oral health care, as well as any dental office, facility or clinic that is associated with such persons.

(3) "Document" means any writing or record of every type that is in your possession, custody or control, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, phone records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

I. Case Information

A. Name of person completing this form: _____

B. Please state the following for the civil action that you filed:

1. Name of the Denture Adhesive Cream User:_____

2. Case caption:_____

3. Name, address, telephone number, fax number and e-mail address of principal attorney representing you:

_____
Name

_____
Firm

_____
Street Address

_____
City, State and Zip Code

_____
Telephone Number Fax Number

_____
E-mail address

C. If you are completing this questionnaire in a representative capacity (on behalf of the estate of a deceased person, incapacitated person, or a minor), please state:

1. Your name:_____

2. Address:_____

3. In what capacity you are representing the individual:_____

4. If you were appointed by a court, state the court and date of appointment:_____
_____

5. Your relationship to deceased or represented person:_____

6. If you represent a decedent's estate, state the date of death of decedent:_____

II. Personal Data of the Denture Adhesive Cream User[1]

A. Maiden name or any other names used and dates of use:_____

B. Identify each address at which you have resided since 1995 to the present, starting with your current address, and list when you started and stopped living at each address:

Address	Dates of Residence

C. Driver's License Number and State Issuing License:_____

D. Social Security Number:_____

E. Date and place of birth:_____

F. Sex: Male_____ Female_____

G. For your current and each former marriage, please list the following information for each spouse:

Name and Current Address of Spouse, if known	Date of Birth	Date of Marriage, if applicable	Date Marriage Ended, if applicable	How Marriage Ended	Occupation (current spouse only)

H. Has your spouse filed a loss of consortium claim in this action? Yes_____ No_____

[1] In sections II through XIV, the Denture Adhesive Cream User is also referred to as "User," "you" or "your."

I. For each of your children, state his/her name, age, and state of residence: _____

_____

_____

J. Employment Information.

Beginning with your current employer (if not currently employed, last employer), list the following for each employer you have had since 1995 to the present:

Name	Address	Dates of Employment	Job Title

K. Education. Please identify the schools you have attended (high school and beyond):

Name of School	Address	Dates of Attendance	Degree or Diploma Awarded and Date Received	Major or Primary Field of Study

L. Have you ever applied for worker's compensation, social security, or state or federal disability benefits? Yes_____ No_____

If "yes," then as to each application, separately state:

1. Date (or year) of application, type of benefits, and the reason for your claim:_____

_____

2. Amount awarded or stated reason for denial, if denied:

_____

3. To what agency or company did you submit your application (for example, Pennsylvania Division of Social Security):_____

M. Have you ever been out of work for more than thirty (30) days in any one (1) year for reasons related to your health condition (other than pregnancy)? Yes_____ No_____

If "yes," please state the dates you were out of work, your employer, if any, on those dates, and describe the condition(s) that kept you from working:

_____

_____

_____

N. Have you ever served in the U.S. Military? Yes ____ No____

If "yes," were you ever rejected or discharged from military service for any stated reason relating to your health, physical, emotional or psychiatric condition? Yes_____ No_____

If "yes," describe the condition and the date upon which you were rejected or discharged from military service, and identify the military branch in which you were serving, or were considered for service, at that time. _____

_____

_____

O. Within the past 20 years, have you filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury, sickness or disease? Yes_____ No_____

If "yes," state the court in which such action was filed, the case name and/or names of adverse parties, and the civil action or docket number assigned to each such claim, action, or suit. _____

_____

Have you *ever* filed a lawsuit or made a claim, other than in the present suit, relating to the same or similar injuries or conditions you claim in this case? Yes_____ No_____

If "yes," state the court in which such action was filed, the case name and/or names of adverse parties, and the civil action or docket number assigned to each such claim, action, or suit. _____

_____

P. In the last 10 years, have you been convicted of or pled guilty to any felony and/or have you been convicted of or pled guilty to *any* crime that involved an alleged act of dishonesty or providing a false statement? [Rule 609 Federal Rules of Evidence] Yes_____ No_____

If "yes," state the date of such conviction or plea, the court in which such conviction or plea was entered and the nature of the felony and/or other crime. _____

_____

III. Oral Health Care Providers of the Denture Adhesive Cream User

A. Please list to the best of your knowledge every Oral Health Care Provider (beginning with your *current* dentist) whom you have seen or from whom you have ever received oral or dental care or treatment (including fitting and treatment for dentures, repair

and/or replacement of dentures) since 5 years before you first got denture(s) to the present. Please **circle** the Name of the Oral Health Care Provider that you ***last*** saw for any reason.

Full Name and Specialty, if any	**Complete Address**	**Treatment Provided**	**Approximate Dates**

IV. Dentures

A. Use of Dentures

1. Reason you use dentures:

   a. Please describe in your own words why you need dentures (for example, an accident causing tooth loss (describe accident), loss of tooth enamel or bone, mouth or gum disease, lack of oral hygiene, or other reason). _____
   _____
   _____
   _____

   b. If any Oral Health Care Provider or Health Care Provider told you about a medical or oral condition requiring you to use dentures, please state the Provider's full name and address, the date(s) the Provider informed you, and what you were told by the Provider. _____
   _____
   _____
   _____

2. Please provide the following information for any tooth extraction done in preparation for denture use:

   a. number of teeth extracted: _____

   b. location of teeth extracted: _____

   c. name of Oral Health Care Provider or Health Care Provider performing extraction: _____

   d. date of extraction: _____

3. Date of first use of dentures: _____

4. Date of last use of dentures (if ongoing, please state): _____

5. State the type of dentures you wear/have worn and the approximate beginning and ending dates you wore each: (a) uppers only; (b) lowers only; (c) both uppers and lowers; (d) partials; (e) other (please specify):_____
_____
_____
_____

6. The last date you saw an Oral Health Care Provider *regarding your dentures* and the name of the Provider seen: _____
_____

V. Denture Adhesive Creams

A. With respect to your use of *any* Denture Adhesive Cream at any time (including but not limited to Poligrip and/or Fixodent)

Please answer the following:

Brand *and* Type of each Denture Adhesive Used	Date of First Use and Dates of Any Later Use	Name(s) of Oral Health Care Provider(s), if any, that you were seeing during the time period you indicate in Column 2

B. Prior to or during your use of any denture adhesive cream, were you given any information by any Oral Health Care Provider(s) or Health Care Provider(s) regarding use of denture adhesive cream (information may include oral or written instructions, directions, advice, warnings, or other types of information)? Yes_____ No_____

If yes, please state:

1. The date(s) on which such oral instructions, directions, advice, warnings, or other information regarding use of denture adhesive cream were given to you:
_____
_____

2. Name and address of any Oral Health Care Provider or Health Care Provider who gave the oral instructions, directions, advice, warnings or other information regarding use of denture adhesive cream to you:_____

_____

_____

3. To the best of your ability, describe what you were told about the use of denture adhesive cream by *each* Oral Health Care Provider or Health Care Provider you identified in 2 above. _____

Provider 1 [Name of Provider and Information Given]:_____

_____

_____

Provider 2 [Name of Provider and Information Given]:

_____

_____

Provider 3 [Name of Provider and Information Given]: _____

_____

_____

VI. Medical Background of the Denture Adhesive Cream User

A. General Background

1. Height: _____

2. Current Weight: _____

B. Smoking/Tobacco Use History

1. Ever smoked cigarettes? Yes ____ No ____

   a. If "yes," provide the date you started smoking:_____

2. Current smoker of cigarettes? Yes ____ No ____

   a. If "yes," state the number of packs smoked per day:_____

3. Former smoker of cigarettes? Yes_____ No_____

   a. If "yes," provide the date you permanently stopped smoking:_____

   b. If "yes," state the number of packs smoked per day before you permanently stopped:_____

4. Any other form of tobacco use (pipe tobacco, snuff, chewing tobacco, dipping, cigars)? Yes_____ No_____

a. If "yes," then state what form, dates of use, and amount of use as to each:

_____

5. Has the number of cigarettes smoked per day, or other daily tobacco use, changed over the last 5 years? Yes_____ No_____

a. If "yes," then please briefly describe the change in usage of each:

_____

_____

C. Alcohol Consumption

1. Have you in the past drunk alcohol (beer, wine, whiskey, etc.)? Yes ____ No ____

a. If "yes," provide the date you started consuming alcohol:

_____

2. Do you currently drink alcohol? Yes ____ No ____

a. If yes, check below which best describes your alcohol consumption.

_____ Less than 1 drink per week
_____ Less than 1 drink per month
_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 10 or more drinks per week
_____ 20-30 drinks per month
_____ 30-40 drinks per month
_____ Over 40 drinks per month

b. If you have ever but do not currently drink alcohol, check below which best describes your former alcohol consumption.

_____ Less than 1 drink per week
_____ Less than 1 drink per month
_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 10 or more drinks per week
_____ 20-30 drinks per month
_____ 30-40 drinks per month
_____ Over 40 drinks per month

3. If you have ever but do not currently drink alcohol, provide the date you last consumed any alcohol: _____

4. Has your weekly or monthly alcohol consumption pattern changed over the last 5 years? Yes_____ No_____

a. If "yes," then please describe the change:_____

_____

_____

D. Illicit Drugs

1. Have you ever used marijuana regularly (more than once a month) during a period of 3 or more consecutive months? Yes_____ No_____ Don't Recall_____

a. If "yes," please state how often you used it, and the date of your last use:

_____

_____

2. Have you ever regularly used (more than once a month) any illicit drugs, other than marijuana, during a period of 3 or more consecutive months (examples include but are not limited to: cocaine/crack cocaine; heroin, opiates, or methadone; hallucinogens such as LSD, Ecstasy, ICE, PCP, MDMA or similar substances; amphetamines, crystal meth, or other stimulants; barbiturates or other sedatives)?

Yes_____ No_____

If "yes," please state what you used, how often you used it, and the date of your last use:_____

_____

E. Nutritional History

1. Have you ever followed any special diets or dietary restrictions for more than 3 consecutive months, for example, for the purpose of weight loss, a health condition such as diabetes or high blood pressure, allergic reactions, or other reason? Yes ___ No ___

If "yes," for each type of diet listed below, give a general description of the diet, the dates you followed that diet, the reason for the diet (for example, to lose weight; to control blood pressure, diabetes, or allergies; to correct nutritional or other imbalance), whether the diet was prescribed or recommended by a health care provider, and if so, the name of the health care provider.

a. Diet or nutritional program you designed yourself:

_____

_____

_____

b. Physician-prescribed diet:

_____

_____

_____

c. Any other diet program (examples include Adkins, South Beach, Pritikin, Jenny Craig, Weight Watchers, vegetarian, low fat, high protein, gluten-free, etc.)

_____

_____

_____

2. Do you regularly drink soda or other carbonated beverages? Yes ____ No ____

If "yes," please state the type of the soda you drink, whether diet or regular, and the amount of soda you drink per day. _____

_____

_____

_____

F. To the best of your knowledge have you ever suffered from or been diagnosed by a doctor or other health care provider with:

		Yes	No	I Don't Recall
1.	Anemia	_____	_____	_____
2.	Leucopenia	_____	_____	_____
3.	Neutropenia	_____	_____	_____
4.	Hypocupremia or Copper Deficiency	_____	_____	_____
5.	Hyperzincemia or Zinc Overload	_____	_____	_____
6.	Vitamin B12 Deficiency	_____	_____	_____
7.	Other Vitamin Deficiency	_____	_____	_____
8.	Myelodysplasia	_____	_____	_____
9.	Myelofibrosis	_____	_____	_____
10.	Diabetes	_____	_____	_____
11.	Wilson's Disease	_____	_____	_____
12.	Menkes' Disease	_____	_____	_____
13.	Myasthenia Gravis	_____	_____	_____
14.	Multiple Sclerosis	_____	_____	_____
15.	Parkinson's Disease	_____	_____	_____
16.	Amyotropic Lateral Sclerosis (ALS; Lou Gehrig's Disease)	_____	_____	_____
17.	Alzheimer's Disease	_____	_____	_____
18.	Cancer/Malignancy	_____	_____	_____
19.	Uremia	_____	_____	_____
20.	Liver Disease	_____	_____	_____

21.	Rheumatoid Arthritis	_____	_____	_____
22.	Celiac Disease	_____	_____	_____
23.	Inflammatory Bowel Syndrome or Disease	_____	_____	_____
24.	Small Intestine/Bowel Bacterial Overgrowth	_____	_____	_____
25.	Other Malabsorption or Gastrointestinal Disorder	_____	_____	_____
26.	Short Bowel Syndrome	_____	_____	_____
27.	Gastric or Intestinal Ulcers	_____	_____	_____
28.	Aceruloplasminemia	_____	_____	_____
29.	Any Immunologic or Autoimmune disorder	_____	_____	_____
30.	Head, Neck, or Back Trauma or Injury	_____	_____	_____
31.	Brain Injury	_____	_____	_____
32.	Cognitive Deficits	_____	_____	_____
33.	Injury to Spinal Cord	_____	_____	_____
34.	Disease or injury of vertebra or disc	_____	_____	_____
35.	Occipital Horn Syndrome	_____	_____	_____
36.	Subacute Combined Degeneration of the Spinal Cord	_____	_____	_____
37.	Myelopathy (disease or injury of spinal column)	_____	_____	_____
38.	Neuropathy or Peripheral Neuropathy (disease or injury to nerves other than spinal column)	_____	_____	_____
39.	Myeloneuropathy or Combined Systems Disease	_____	_____	_____
40.	Anorexia Nervosa	_____	_____	_____
41.	Bulimia Nervosa	_____	_____	_____
42.	Malnutrition	_____	_____	_____
43.	Any Neurologic (nerve) Disease or Disorder	_____	_____	_____
44.	Any Hematologic (blood) Disease or Disorder	_____	_____	_____

If "yes," please state separately for each:

Type of Condition	**Date of First Symptoms**	**Date of Diagnosis**	**Diagnosing Doctor**

G. Have you ever undergone dialysis, tube feeding, and/or intravenous feeding? If so, please provide the reason(s) for such treatment, and frequency and dates of such treatment: _____

_____

_____

H. Have you ever had bariatric, gastrointestinal and/or other weight loss surgery? If so, please provide the reason(s) for the surgery, the date of the surgery, the name of the surgeon who performed the surgery, and the facility at which the surgery was performed:

_____

_____

_____

VII. Medications, Vitamins, or Supplements Used by the Denture Adhesive Cream User

To the best of your knowledge, state whether you used any of the following medications, vitamins or supplements at any time beginning 5 years before your first use of any denture adhesive cream to the present OR in the past 15 years, whichever date is earlier. Circle all medications you have used, state the first and last dates you took the medication, and identify the doctor that prescribed the medication, vitamins or supplements.

Medication	Dates Used (first to last use)	Prescribing Doctor, if applicable	Reason for Use/Prescription, if applicable
Any Multivitamin preparation (including but not limited to Centrum, One-A-Day, Stuart, Oncovite, Nature Made, Stresstabs, Weil, Prescriptive Formulas, Vitafusion, Viactiv, Rite Aid, Walgreens, Twinlab, Geritol, Natrol)			

Medication	Dates Used (first to last use)	Prescribing Doctor, if applicable	Reason for Use/Prescription, if applicable
Any supplements, sprays, swabs, lozenges, or other products containing Zinc (including but not limited to GNC Zinc 50, GNC Zinc 100, ICaps, Ocuvite, Sunkist Zinc Throat Lozenges, Tung Gel, Zand Herbalozenge, GNC Ultra Zinc Lozenges, Cold-Eeze, TheraBreath Chewing Gum, EAS Myoplex, Zicam Cold Remedy Nasal Gel or Gel Swaps, Zicam Cold Remedy, Zicam Healthy Z-ssentials)			
Any and all other prescription and non-prescription medications, including vitamin supplements, herbal supplements or remedies, or homeopathic remedies.			
Name:_____ _____ _____ _____ _____ _____ _____ _____ _____ _____			

VIII. Injuries, Symptoms, Diagnoses, Ailments, and Damages of the Denture Adhesive Cream User

A. Are you claiming that you have developed or may develop any injury or damage or condition (including any alleged physical, injury or damage) as a result of using denture adhesive cream? Yes_____ No_____

If "yes," then for ***each*** such injury, damage or condition, answer the following:

1. Describe each injury, damage or condition that you are claiming was caused by your use of any Denture Adhesive Cream, including in your description the date you became aware of each injury, damage or condition:

_____
_____
_____
_____
_____

2. Describe all of the symptoms you are experiencing that you claim result from use of denture adhesive cream.

_____
_____
_____
_____
_____

3. For each of the symptoms you describe in No. 2 above, going back ten (10) years from your first use of dentures, when was the ***first time*** (the earliest date) you can remember ever having that symptom, , even if the symptom went away:

Symptom:_____
First Time (earliest date):_____

Symptom:_____
First Time (earliest date):_____

Symptom:_____
First Time (earliest date):_____

Symptom:_____
First Time (earliest date):_____

4. For each such injury, damage, condition, or symptom that you have described in this Section VIII (A) (1-2) above, have you consulted with any Health Care Provider(s) or Oral Health Care Provider(s) with respect to your alleged denture adhesive cream-related injury(ies)? Yes_____ No_____

If "yes," for each Health Care Provider or Oral Health Care Provider, state:

Name of Health Care Provider or Oral Health Care Provider	**Address of Health Care Provider or Oral Health Care Provider**	**Dates of Consultation/Treatment and Nature of Injury, Damage, Condition or Symptom**

B. Did you ever suffer from these types of injuries, damages, or conditions, or have any symptoms of these types of injuries, damages, or conditions, prior to your use of denture adhesive cream? Yes_____ No_____

If "yes," for each such injury, damage, condition or symptom, state:

Description of Injury, Damage, Condition or Symptom	**Date(s) You Had the Injury, Damage, Condition or Symptoms**	**Health Care Provider or Oral Health Care Provider Visited, if any**	**Dates of Consultation/Treatment with Health Care Provider or Oral Health Care Provider, if any**

C. Have you ever undergone any of the following medical tests?

1. Magnetic Resonance Imaging (MRI) of the brain: Yes_____ No_____

2. Magnetic Resonance Imaging (MRI) of the spine: Yes_____ No_____

3. Electromyogram (EMG): Yes_____ No_____ Unsure _____

4. Evoked Potentials Tests (including but not limited to Somatosensory Evoked Potentials (SSEP) tests): Yes_____ No_____ Unsure _____

5. Nerve Conduction Velocity Study (NCVS): Yes_____ No_____ Unsure_____

If "yes" to any of the above, please state for *each*:

a. The name of *each* test:
_____
_____

b. The date *each* test was ordered: _____
_____

c. The Health Care Provider that ordered *each* test: _____
_____
_____

d. The date and location where *each* test was administered: _____
_____
_____

e. Your best knowledge and information as to whether *each* test showed any problem, and, if so, what each test showed and/or what you were told by any Health Care Provider that each test showed:_____
_____
_____
_____

D. Do you allege that the use of denture adhesive cream aggravated a pre-existing condition?
Yes_____ No_____

If "yes," for each such pre-existing condition, state:

a. A Description of the Pre-Existing Condition: _____
_____
_____

b. The date when any pre-existing condition first arose:_____
_____
_____

c. The date any pre-existing condition was first diagnosed:_____
_____
_____

d. The name and address of any healthcare provider or oral health care provider who provided care for any pre-existing condition: _____
_____
_____

E. Have you ever had laboratory work performed that measured your whole blood, serum, plasma, or urine levels for zinc, copper and/or ceruloplasmin?
Yes_____ No_____ Unsure _____

If "yes," then based on your best recollection, separately state for zinc, copper and/or ceruloplasmin *each* time they were measured:

a. The zinc, copper and/or ceruloplasmin level(s) found and whether the level(s) were low, normal or high. (If specific level is unknown, please provide/describe your best knowledge and information about whether the result(s) were low, normal, or high as to each test performed and/or what you were told as to whether your zinc and/or copper level(s) were low, normal or high):_____
_____
_____
_____

b. The date(s) the blood was drawn (or urine sample provided):_____
_____
_____

c. The lab or facility that performed the test:_____
_____

d. The type of test (whole blood, serum, plasma, or urine):_____
_____

F. Has any Health Care Provider or Oral Health Care Provider told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages, conditions, or symptoms that you describe in this Section VIII above are associated with your use of any denture adhesive cream? Yes_____ No_____

If "yes," then state and describe:

1. What you (or your agents, representatives or anyone acting on your behalf) were told:
_____
_____
_____

2. (a) The name(s) of the Health Care Provider or Oral Health Care Provider who told you (or your agents, representatives or anyone acting on your behalf) and (b) when:

_____

_____

_____

G. Has any Health Care Provider or Oral Health Care Provider ever told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages or conditions that you describe in this Section VIII above are associated with any factors *other than* your use of any denture adhesive cream? Yes_____ No_____

If "yes," then state and describe:

1. What you (or your agents, representatives or anyone acting on your behalf) were told:

_____

_____

_____

2. (a) The name(s) of the Health Care Provider or Oral Health Care Provider who told you (or your agents, representatives or anyone acting on your behalf) and (b) when:

_____

_____

H. Excluding future medical expenses are you claiming that you have paid or will have to pay any expenses as a result of having used any denture adhesive cream? Yes_____ No_____

If "yes," then for each item separately identify:

Reason Expense was Incurred	**Amount of Fees or Expenses**	**Person or Company Paid or to be Paid**

I. Are you claiming to have suffered any mental anguish or emotional injury as a consequence of using any denture adhesive cream?

Yes_____ No_____

If "yes," have you received any counseling/care/treatment by any mental health care provider for the mental anguish or emotional injury you are claiming?

Yes___ No___

If "yes," then state:

The full name, address and specialty of each mental health care provider you have seen for the mental anguish or emotional injury you are claiming, and the approximate date(s) of any visits with each: _____

_____

_____

J. Do you claim psychological or psychiatric injury (other than the mental anguish or emotional distress described above) as a consequence of using any denture adhesive cream.

Yes___ No___

If "yes," have you received any counseling/care/treatment by any mental health care at any time for any psychological or psychiatric conditions?

Yes___ No___

If "yes," then state:

The full name, address and specialty of each mental health care provider you have *ever seen for any reason* and the approximate date(s) of any visits with each:_____

_____

_____

_____

K. Fact Witnesses

Please identify all persons who you believe possess information concerning your claimed injury(ies) and damages other than your Healthcare Providers and/or Oral Healthcare Providers, and please state their name address and his/her/their relationship to you:

Name:_____

Address:_____

_____

Relationship to you:_____

Name:_____

Address:_____

_____

Relationship to you:_____

Name:_____

Address:_____

_____

Relationship to you:_____

IX. Family History of the Denture Adhesive Cream User

A. To the best of your knowledge did any child, parent, sibling, or grandparent of the Denture Adhesive Cream User have any of the conditions or experiences identified in Section VI (F) beginning on page ____?

Yes_____ No_____ Unsure _____

B. If "yes," or "unsure," then based on your best recollection, state separately for each: person the relationship to you, the type of health problem, and the date and cause of death (if applicable): _____
_____
_____
_____
_____

X. Health Care Providers of the Denture Adhesive Cream User

A. Provide the requested information for each of the following Health Care Providers and health care facilities:

Beginning with your current family and/or primary care physician(s), please list your family and/or primary care physicians in the time period from 10 years preceding your first use of dentures to the present.

Name	Address	Approximate Dates

B. Provide the requested information for each hospital, clinic, or health care facility where you have received inpatient or outpatient treatment (including treatment in an emergency room) or been admitted as a patient during the time period from 10 years preceding your first use of dentures to the present.

Name	**Address**	**Admission/ Treatment Dates**	**Reason for Admission/ Treatment**	**Treatment Received**

C. Provide the requested information for each surgery or operation that you have ever undergone, including oral surgery but not including surgery related to childbirth.

Name and Address of Hospital, Treating Physician and Surgeon	**Type of Surgery or Operation**	**Date of Surgery or Operation**	**Reason for Surgery or Operation**

D. Provide the information requested for every other Health Care Provider (as defined at beginning of this questionnaire) or facility (not identified in A-C above) whom you have seen or consulted or from whom you have received treatment, evaluation, or testing for *any* reason, or at which you've been treated, evaluated or tested for *any r*eason, during the time period of 10 years preceding your first use of dentures to the present.

Name and Specialty, if any	**Address**	**Dates of Treatment/ Admission/ Visit**	**Reason for Treatment/ Admission/Visit**	**Treatment Received**

E. Provide the requested information for each pharmacy that has dispensed medication to you for the time period of 10 years preceding your first use of dentures to the present:

Name	**Address**	**Years When You Used Pharmacy**

XI. Insurance Providers of the Denture Adhesive Cream User

A. Have you ever had health, prescription, dental, disability, or worker's compensation insurance coverage at any time? Yes ____ No _____

If "yes," then as to each insurance provider, please provide:

Insurance Provider Name and Address/ Telephone Number, if available	**Name and Address of Policy Holder/Insured (if different than you)**	**Subscriber/ Group ID Number and Policy/ Identification Number**	**Approximate Dates of Coverage**	**Type of Coverage (e.g., health, dental, comp)**

B. Have you ever been denied health, dental, or disability insurance coverage? Yes_____ No_____

If "yes," state the date of such denial, the name of the insurance company, and the stated reason for such denial, if known. _____
_____
_____

C. Have you ever been denied life insurance? Yes_____ No_____

If "yes," state the date of such denial, the name of the insurance company, and the stated reason for such denial, if known. _____
_____
_____

XII. Use of Poligrip

If you have used Poligrip denture adhesive cream at any time, please answer the following questions. If not, please leave blank.

A. Date of first use of Poligrip: _____

B. Date of last use of Poligrip (if ongoing, please state): _____

C. If you have discontinued your use of Poligrip, state the reason you stopped using Poligrip:

_____

_____

1. If you discontinued your use of Poligrip, were you advised to stop using Poligrip by a Health Care Provider or Oral Health Care Provider? Yes _____ No_____

2. If you answered yes above, state the name of the Provider and the approximate date you were so advised: _____

_____

D. Did you use Poligrip continuously during the time period described in (A) and (B) above?

_____

E. If you did not use Poligrip continuously, state the dates or time periods you used Poligrip:

_____

_____

_____

F. The type(s) of Poligrip you normally use or used (for example, Super Poligrip Original, Super Poligrip Free, Super Poligrip Ultra Fresh, Super Poligrip Extra Care with Poliseal, or other): _____

_____

G. The tube size of Poligrip you normally purchase or purchased (for example, 2.4 oz [68g], 1.4 oz [40g], or other):_____

_____

H. If you have used more than one type of Poligrip, state the type of Poligrip and the approximate dates or time periods of use of each: _____

_____

_____

_____

_____

I. The number of times per week you use/used Poligrip (and, if different over time, describe and provide the dates or time periods of each such usage):_____

_____

J. For your ***upper*** denture, the number of times per day you apply/applied Poligrip to your upper dentures (and, if different over time, describe and provide the dates or time periods of each such usage): _____
_____
_____

K. For your ***lower*** denture, the number of times per day you apply/applied Poligrip to your lower dentures (and, if different over time, describe and provide the dates or time periods of each such usage): _____
_____
_____

L. Did you or do you clean your dentures before each application of Poligrip? Yes___ No___ Sometimes ___

1. If you answered yes or sometimes, please describe your denture cleaning process:
_____
_____
_____

M. Do you have other dental appliance(s) (for example, bridge, plate, mouth guard, crown) to which you applied/apply Poligrip? Yes__ No__

1. If yes, please identify the appliance(s) and the number of times per day that you use Poligrip with each appliance: _____
_____
_____

N. Every store or pharmacy where Poligrip was purchased by you or on your behalf and the approximate dates of purchase: _____
_____
_____
_____
_____

O. Identify every Oral Health Care Provider from whom you received Poligrip: _____
_____
_____

P. The number of 2.4 oz tubes of Poligrip you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: _____

2. one month: _____

3. 6 months: _____

4. 1 year: _____

5. Other (for example, one 2.4 oz tube every 10 days):_____

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

_____

_____

Q. The number of 1.4 oz tubes of Poligrip you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: _____

2. one month: _____

3. 6 months: _____

4. 1 year: _____

5. Other (for example, one 1.4 oz. tube every 10 days)

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

_____

_____

R. Briefly describe, separately as to your ***upper*** denture and ***lower*** denture, your typical application process of Poligrip to your dentures, including *but not limited to* (a) whether you use separate drops or a solid line of adhesive on each denture; (b) where on each denture you apply adhesive; (c) whether your typical application results in any ooze or overflow. (If your application process has changed over the years, separately describe each application process used and provide the dates or time periods of each such usage.)

_____

_____

_____

_____

XIII. Use of Fixodent

If you have used Fixodent denture adhesive cream at any time, please answer the following questions. If not, please leave blank.

A. Date of first use of Fixodent: _____

B. Date of last use of Fixodent (if ongoing, please state): _____

C. If you have discontinued your use of Fixodent, state the reason you stopped using Fixodent:

_____

_____

1. If you discontinued your use of Fixodent, were you advised to stop using Fixodent by a Health Care Provider or Oral Health Care Provider? Yes _____ No_____

2. If you answered yes above, state the name of the Provider and the approximate date you were so advised: _____

_____

D. Did you use Fixodent continuously during the time period described in (A) and (B) above? _____

E. If you did not use Fixodent continuously, state the dates or time periods you used Fixodent: _____

_____

_____

F. The type(s) of Fixodent you normally use or used (for example, Fixodent Complete, Fixodent Fresh, Fixodent Free, Fixodent Original, Fixodent Comfort, Fixodent Control, Fixodent Control + Scope Flavor, or other): _____

_____

_____

G. The tube size of Fixodent you normally purchase or purchased (for example, 1.4 oz., 2.0 oz., 2.2 oz., 2.4 oz., other):_____

_____

H. If you have used more than one type of Fixodent, state the type and the approximate dates or time periods of use of each: _____

_____

_____

_____

_____

I. The number of times per week you use/used Fixodent (and, if different over time, describe and provide the dates or time periods of each such usage):_____

J. For your ***upper*** denture, the number of times per day you apply/applied Fixodent to your upper dentures (and, if different over time, describe and provide the dates or time periods of each such usage): _____

_____

_____

K. For your ***lower*** denture, the number of times per day you apply/applied Fixodent to your lower dentures (and, if different over time, describe and provide the dates or time periods of each such usage): _____

_____

_____

L. Did you or do you clean your dentures before each application of Fixodent? Yes__ No__ Sometimes ___

1. If you answered yes or sometimes, please describe your denture cleaning process:

_____

_____

_____

M. Do you have other dental appliance(s) (for example, bridge, plate, mouth guard, crown) to which you applied/apply Fixodent? Yes__ No__

1. If yes, please identify the appliance(s) and the number of times per day that you use Fixodent with each appliance: _____

_____

N. Every store or pharmacy where Fixodent was purchased by you or on your behalf and the dates of purchase: _____

_____

_____

_____

O. Identify every Oral Health Care Provider from whom you received Fixodent: _____

_____

_____

P. The number of 2.4 oz tubes of Fixodent you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: _____

2. one month: _____

3. 6 months: _____

4. 1 year: _____

5. Other (for example, one 2.4 oz tube every 10 days):_____

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

_____

_____

Q. The number of 1.4 oz tubes of Fixodent you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: _____

2. one month: _____

3. 6 months: _____

4. 1 year: _____

5. Other (for example, one 1.4 oz tube every 10 days):_____

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

_____

_____

R. Briefly describe, separately as to your ***upper*** denture and ***lower*** denture, your typical application process of Fixodent to your dentures, including *but not limited to* (a) whether you use separate drops or a solid line of adhesive on each denture; (b) where on each denture you apply adhesive; (c) whether your typical application results in any ooze or overflow. (If your application process has changed over the years, separately describe each application process used and provide the dates or time periods of each such usage.)

_____

_____

XIV. Request for Production of Documents Directed to Plaintiff(s)

Please produce the following non-privileged documents (including but not limited to emails and internet articles or postings) with this Fact Sheet, to the extent that such documents are currently in your possession or in the possession of your lawyers:

1. All documents you or anyone acting on your behalf reviewed in preparation of this Fact Sheet.

2. A copy of all medical records regarding the Denture Adhesive Cream User from any Health Care Provider who treated the Denture Adhesive Cream User for any disease, condition or symptom referred to in response to the questions above.

3. A copy of all dental records regarding the Denture Adhesive Cream User from any Oral Health Care Provider who has treated the Denture Adhesive Cream User for any reason, including for the care and fitting of dentures.

4. To the extent not included in the foregoing, all records relating to any examination of the Denture Adhesive Cream User by any Health Care Provider or Oral Health

Care Provider, conducted for any purpose during the time period of 10 years preceding your first use of dentures to the present.

5. A copy of any and all purchase receipts showing proof of purchase of Poligrip or Fixodent by the Denture Adhesive Cream User or on his or her behalf.

6. If the Denture Adhesive Cream User has been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

7. Reports of all diagnostic tests, including but not limited to blood tests, peripheral blood smears, bone marrow smears or testing, electromyograms, nerve conduction studies, somatosensory evoked potential studies, visual evoked potential studies, brainstem auditory evoked potential studies, other neurological testing, X-rays, MRIs, CT scans, and other imaging studies administered to the Denture Adhesive Cream User at any time.

8. Copies of all documents in your possession from physicians, Health Care Providers, Oral Health Care Providers or others relating to the use of Denture Adhesive Cream, or to any condition you claim is related to the use of Denture Adhesive Cream, or recording or reflecting the use of any Denture Adhesive Cream by the Denture Adhesive Cream User.

9. All documents constituting, concerning, or relating to product use instructions, product warnings, package inserts or other materials obtained by the Denture Adhesive Cream User or his or her agents, representatives or anyone acting on the Denture Adhesive Cream User's behalf (other than your attorneys in this case) in connection with the use of any Denture Adhesive Cream, including but not limited to Poligrip and/or Fixodent. This request seeks documents already in your possession, or that come into your possession, that were and/or are obtained by you from any source *other than* the documents that Defendants either have or may produce during the course of discovery in this lawsuit.

10. All prescriptions, prescription records, drug containers and labels, informational brochures, advertisements, package inserts and other documents setting forth warnings and/or instructions relating to any medications, drugs, vitamins or supplements used by the Denture Adhesive Cream User as identified in Section VII of this Fact Sheet.

11. Any diaries, calendars, date books, or other documents which reflect use by the Denture Adhesive Cream User of any medications, drugs, vitamins or supplements and/or which record or reflect the occurrence, duration, or severity of any injury, illness, or disease affecting the Denture Adhesive Cream User within the time period of 10 years preceding your first use of dentures to the present.

12. Any releases, covenants not to sue, and any other agreement(s) between you and any other person relating in any way to the claims asserted in this lawsuit.

13. All press releases or other public statements made by or on behalf of you relating to this litigation (excluding postings on web sites of plaintiffs' attorneys).

14. All documents recording, reflecting or relating to any communication concerning Denture Adhesive Cream (including but not limited to Poligrip and/or Fixodent) that you or anyone acting on your behalf had with any governmental body, regulatory agency, trade group, pharmaceutical manufacturer or distributor, members of the press or news media, or other person (other than any communication with your lawyers in this case).

15. All documents recording, reflecting or relating to any communication that you or anyone acting on your behalf (including your attorneys) has had with any of the GSK Defendants and/or the P&G Defendants, including but not limited to any electronic or tape recording of any such communication(s).

16. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation.

17. All documents that relate to Denture Adhesive Creams (including but not limited to Poligrip and/or Fixodent), any alleged side effect of Denture Adhesive Cream, or the alleged injuries that are the subject of this lawsuit. This request seeks documents already in your possession, or that come into your possession, that were and/or are obtained by you from any source *other than* the documents that Defendants either have or may produce during the course of discovery in this lawsuit.

18. All documents relating to Denture Adhesive Creams or any alleged health risks or hazards related to Denture Adhesive Creams in your possession, or the possession of the Denture Adhesive Cream User, at or before the time of the injury alleged in your Complaint.

19. All documents you or anyone acting on your behalf (and not your lawyer) obtained directly or indirectly from any defendant.

20. All photographs, drawings, journals, slides or videos relating to the injuries alleged in your complaint (excluding materials prepared by Plaintiffs' experts, the production of which will be separate).

21. All documents that record, reflect or relate to any pecuniary loss or other damages, including all out of pocket expense documentation, that you claim resulted from the administration of any Denture Adhesive Cream as alleged in the Complaint.

22. If your complaint includes a claim of loss of support or loss of earnings or earning capacity, produce all W-2s (if you are an employee) and/or the federal income tax returns (if you are self-employed) of the Denture Adhesive Cream User since 1995 to the present.

23. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.

24. Copies of letters testamentary, letters of administration or similar documentation relating to your status as plaintiff (if applicable).

25. Decedent's death certificate (if applicable).

26. Medical or coroner's reports regarding decedent's death (if applicable).

XV. Authorizations

Complete and sign the attached authorizations for release of records.

XVI. Declaration

I declare under penalty of perjury that all of the information provided in this Plaintiff's Fact Sheet is true and correct, that I have supplied all the documents requested in Section XIV of this Plaintiffs' Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

_____ _____

Signature Date

_____

Printed Name

Exhibit B – Authorizations to Accompany Plaintiff Fact Sheet

- **Medical Records**
- **Mental Health Records**
- **Insurance Records**
- **Employment Records**
- **Education/Scholastic Records**
- **Social Security Disability Records**
- **Social Security Earnings Records**
- **Tax Records**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 09-2051-MD-ALTONAGA/Brown

In RE
Denture Cream Products
Liability Litigation
_____/

AUTHORIZATION TO DISCLOSE HEALTH AND INSURANCE INFORMATION PURSUANT TO 45 CFR 164.508 (HIPAA)

TO: _____
Name of Healthcare Provider/Physician/Facility

_____
Address (Street, City, State, Zip Code

RE: Patient Name: _____
Date of Birth: _____ Social Security Number: _____-_____-_____
Address: _____

I, _____, hereby authorize you to release and furnish to *[Check one or both]*:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G) _____;

and/or her/his/their designated agent, **HG Litigation Services,** copies of full and complete protected medical and health information, including the following:

For use in the In Re Denture Cream Products Liability Litigation, MDL 2051. *To my healthcare provider: This authorization is forwarded by attorneys for defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me, unless you receive a separate and additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the records, or any other matter bearing on my medical or physical condition at a deposition or trial.*

- All health information records, including medical, dental and medication records, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians or health care providers.

- All autopsy, laboratory, pathology, histology, cytology, hematology, radiology, CT scan, MRI, EMG, X-rays, Evoked Potentials Tests, SSEP tests, Nerve Conduction Velocity Studies (NCVS), echocardiogram and cardiac catheterization reports.

- All radiology films, CT scans, MRIs, Evoked Potentials tests, SSEP tests, Nerve Conduction Velocity Studies, X-rays, EMGs, mammograms, myelograms, photographs, bone scans, tracings, recordings, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.

- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs

- All billing information, including all statements, itemized bills, insurance records and Medicare/Medicaid claims applications.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. *Unless otherwise revoked, this authorization will expire at conclusion of my involvement in the captioned litigation.*

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

A notarized signature is <u>not</u> required. CFR 164.508. A facsimile or copy of this Authorization shall have the same force as an original.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient Name [Please Print]	**Patient Signature**
Social Security Number	**Date**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 09-2051-MD-ALTONAGA/Brown

In RE
Denture Cream Products
Liability Litigation
_____/

AUTHORIZATION FOR THE RELEASE OF MENTAL HEALTH RECORDS
PURSUANT TO 45 CFR 164.508(a) (2) (HIPAA)

TO: _____
Name of Mental Healthcare Provider/Physician/Facility

_____
Address (Street, City, State, Zip Code)

RE: Patient Name: _____
Date of Birth: _____ Social Security Number: _____-_____- _____
Address: _____

I, _____, hereby authorize you to release and furnish to *[Check one or both]*:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G)_____;

and/or her/his/their designated agent, **HG Litigation Services,** copies of full and complete protected medical and mental health information, including the following:

For use in the In Re Denture Cream Products Liability Litigation, MDL 2051. *To my healthcare provider: This authorization is forwarded by attorneys for defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me, unless you receive a separate and additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the records, or any other matter bearing on my medical or physical condition at a deposition or trial.*

- All psychiatric, psychological or other confidential records relating to my emotional or other psychiatric/psychological condition for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated records custodian of all covered entities under HIPAA identified above disclose full and complete protected medical and mental information including the following:

  - All psychiatric/psychological records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, records received by other physicians, pharmacy and prescription records, billing records and records of billing to third party payers and payment or denial of benefits.

This protected health information is disclosed for the following purposes: The currently pending litigation involving the person named above.

This authorization is given in compliance with 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the representatives of defendants noted above who have agreed to pay reasonable charges made by you to supply copies of such records.

I acknowledge that I have the right to revoke this authorization by written notification to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 CFR 164.508.
I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

I understand that the nature of this authorization is to authorize the release of my mental health records.

A notarized signature is not required. CFR 164.508. A facsimile, copy or photocopy of this Authorization shall have the same force as an original. *Unless otherwise revoked, this authorization shall expire at the conclusion of my involvement in the captioned litigation.*

I have read the above and authorize the disclosure of the protected mental health information as stated.

Patient Name [Please Print]	**Patient Signature**
Social Security Number	**Date**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 09-2051-MD-ALTONAGA/Brown

In RE
Denture Cream Products
Liability Litigation
_____/

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS
Pursuant to 45 CFR 164 (HIPAA)

TO: _____
Name of Entity

_____
Address (Street, City, State, Zip Code)

RE: Plaintiff Name(s): _____ Policy No: _____

Date of Birth: _____ Social Security Number: _____-_____- _____

Insured Name(s) (if different):_____

I, _____, hereby authorize you to release and furnish to *[Check one or both]*:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G) _____;

and/or his/her/their designated agent, **HG Litigation Services,** all my insurance records, including the following:

- All information pertaining to my insurance, including but limited to, all forms and records regarding insurance claims applications and benefits and all medical, health, hospital, physicians, nursing or allied health professional reports, evaluations, records, notes or invoices and bills, which may be in your possession.

I understand that the information in my insurance records may include health information, information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The release of the information listed above is being authorized for purposes of compliance with discovery in the captioned litigation. Any person, firm, or entity that releases information pursuant to this authorization is absolved from any liability that might otherwise result from the release of this information. I understand that I have the right to revoke this authorization at any time by providing to you a written revocation and I agree to simultaneously provide a copy of such revocation to the record requestors identified above. I also understand that any revocation will not apply to information that has already been released in response to this authorization. *Unless otherwise revoked, this authorization shall be continuing in nature and will expire at the conclusion of my involvement in the captioned litigation.*

I understand that authorizing the disclosure of this insurance information (and any health information contained therein) is voluntary. I can refuse to sign this authorization. I understand that treatment, enrollment, or eligibility for, or payment of, benefits may not be conditioned upon the signing of this authorization. I understand that I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that the released information may not be protected by federal privacy regulations and may be redisclosed in conjunction with this litigation.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

A notarized signature is <u>not</u> required. 45 CFR 164.508. A facsimile, copy or photocopy of this Authorization shall have the same force as an original. This authorization complies with 45 CFR 164 regarding the core elements of an authorization pursuant to HIPAA.

I have read the above and authorize the disclosure of my insurance information (and any health information contained therein) as stated.

Plaintiff Name [Please Print]	**Plaintiff Signature**
Social Security Number	**Date**

Policy No._____

Insured Name (if different) _____
Policy/Group Id No._____

85229766.1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 09-2051-MD-ALTONAGA/Brown

In RE
Denture Cream Products
Liability Litigation
_____/

AUTHORIZATION FOR RELEASE OF EMPLOYMENT/PAYROLL RECORDS

TO: _____
Name of Entity

_____
Address (Street, City, State, Zip Code)

RE: Plaintiff/Employee Name(s): _____
Date of Birth: _____ Social Security Number: _____-_____- _____

I, _____, hereby authorize you to release and furnish to *[Check one or both]*:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G)_____;

and/or his/her/their designated agent, **HG Litigation Services,** all my employment/personnel/payroll records, including the following:

- All information, including but not limited to any and all employment records, personnel records, applications for employment, W-2 forms, documents related to the beginning of and termination of employment, employee performance evaluations, payroll records, vacation and illness benefits and use, reprimand/commendation notices, and all other documents, papers, checks and ledgers showing wages, salaries, other earnings and employee benefits, and the amount of time and number of days worked.

The release of the information listed above is being authorized for purposes of compliance with discovery in the captioned litigation. Any person, firm, or entity that releases information pursuant to this authorization is absolved from any liability that might otherwise result from the release of this information. I understand that I have the right to revoke this authorization at any time by providing to you a written revocation and agree to simultaneously provide a copy of such revocation to the record requestors identified above. I also understand that any revocation will not apply to information that has already been released in response to this authorization. *Unless otherwise revoked, this authorization shall be continuing in nature and will expire at the conclusion of my involvement in the captioned litigation.*

A notarized signature is <u>not</u> required. A facsimile, copy or photocopy of this Authorization shall have the same force as an original.

I have read the above and authorize the disclosure of my employment/payroll/personnel information as stated.

_____ _____
Plaintiff/Employee [Please Print] **Signature**

_____ _____
Social Security Number **Date**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 09-2051-MD-ALTONAGA/Brown

In RE
Denture Cream Products
Liability Litigation
_____/

AUTHORIZATION FOR RELEASE OF SCHOLASTIC/EDUCATION RECORDS

TO: _____
Name of Entity

_____
Address (Street, City, State, Zip Code)

RE: Plaintiff Name(s): _____
Date of Birth: _____ Social Security Number: _____-_____- _____

I, _____, hereby authorize you to release and furnish to *[Check one or both]*:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G)_____;

and/or his/her/their designated agent, **HG Litigation Services,** my education and scholastic records, as follows:

- Dates of attendance at your school/institution and any diplomas, certificates or degrees obtained.

The release of the information listed above is being authorized for purposes of compliance with discovery in the captioned litigation. Any person, firm, or entity that releases information pursuant to this authorization is absolved from any liability that might otherwise result from the release of this information. I understand that I have the right to revoke this authorization at any time by providing to you a written revocation and agree to simultaneously provide a copy of such revocation to the record requestors identified above. I also understand that any revocation will not apply to information that has already been released in response to this authorization. *Unless otherwise revoked, this authorization shall be continuing in nature and will expire at the conclusion of my involvement in the captioned litigation.*

A notarized signature is <u>not</u> required. A facsimile, copy or photocopy of this Authorization shall have the same force as an original.

I have read the above and authorize the disclosure of my education and scholastic information as stated.

_____ _____
Plaintiff Name [Please Print] **Signature**

_____ _____
Social Security Number **Date**

Form Approved
OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- **nonmedical** records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

How to Complete This Form

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the **nonmedical** information applies, or
- the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PRIVACY ACT NOTICE: The Privacy Act Notice requires us to notify you that we are authorized to collect this information by section 3 of the Privacy Act. You do not have to provide the information requested. However, we cannot release information or records about you to another person or organization without your consent for release of information. Your records are confidential. We will release only records that you authorize, and only to persons or organizations who you authorize to receive that information.

PAPERWORK REDUCTION ACT STATEMENT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 212345-6401. Send only comments relating to our time estimate to this address, not the completed form.*

Form Approved
OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

XX Social Security Number
XX Identifying information (includes date and place of birth, parents' names)
XX Monthly Social Security benefit amount
XX Monthly Supplemental Security Income payment amount
XX Information about benefits/payments I received from _____ to _____
XX Information about my Medicare claim/coverage from _____ to _____
XX (specify) _____
Medical records
XX Record(s) from my file (specify) Entire file is requested
_____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)
Date: _____ Relationship: _____

Form **SSA-3288** (5-2007) EF (5-2007)

Form Approved
OMB No. 0960-0525

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. **Certified/Non-Certified Detailed Earnings Information**

   Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. **Certified Yearly Totals of Earnings**

   Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

These totals can be obtained by calling 1-800-772-1213 to receive Form SSA-7004, Request for Earnings and Benefit Estimate Statement.

PRIVACY ACT NOTICE: We are authorized to collect this information under section 205 of the Social Security Act, and the Federal Records Act of 1950 (64 Stat. 583). It is needed so we can identify your records and prepare the statement you request. You do not have to furnish the information, but failure to do so may prevent your request from being processed.

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 11 minutes to read the instructions, gather the necessary facts, and answer the questions.

INFORMATION ABOUT YOUR REQUEST

- **How Do I Get This Information?**

  You need to complete the attached form to tell us what information you want.

- **Can I Get This Information For Someone Else?**

  Yes, if you have their written permission. For more information, see page 3.

- **Who Can Sign On Behalf Of The Individual?**

  The parent of a minor child, or the legal guardian of an individual who has been declared legally incompetent, may sign if he/she is acting on behalf of the individual.

- **Is There A Fee For This Information?**

  1. **Certified/Non-Certified Detailed Earnings Information**

     Yes, we usually charge a fee for detailed information. In most cases, this information is used for purposes NOT directly related to Social Security such as for a private pension plan or personal injury suit. The fee chart on page 3 gives the amount of the charge.

     Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.

     Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

     We will certify the detailed earnings information for an additional fee of $15.00. Certification is usually not necessary unless you plan to use the information in court.

  2. **Certified Yearly Total of Earnings**

     Yes, there is a fee of $15 to certify yearly totals of earnings. Cetification is usually not necessary unless you plan to use the information in court.

  3. **Method of Payment**

     Enclose a check or money order for the entire fee required. Payment can also be made by credit card. To do so, complete page 4 of this form and return it with your request form.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

   Print the Name, Social Security Number (SSN), and date of birth below.

   Name _____ Social Security Number _____

   Other Name(s) Used (Include Maiden Name) _____ Date of Birth (Mo/Day/Yr) _____

2. What kind of information do you need?

   ☐ **Detailed Earnings Information** (If you check this block, tell us below why you need this information.) For the period(s)/year(s): _____

   _____

   _____

   ☐ **Certified Total Earnings For Each Year.** (Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement) For the year(s): _____

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 . . . . . A. $ _____

   Do you want us to certify the information? ☐ Yes ☐ No

   If yes, enter $15.00 . . . . . B. $ _____

   ADD the amounts on lines A and B, and enter the TOTAL amount . . . . . C. $ _____

   - You can pay by CREDIT CARD by completing and returning the form on page 4, or
   - Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payble to "Social Security Administration"
   - DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

   SIGN your name here (Do not print) > _____ Date _____

   Daytime Phone Number _____ _____ (Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

   Name _____ Address _____

   City, State & Zip Code _____

6. Mail Completed Form(s) To:

   Social Security Administration
   Division of Earnings Record Operations
   P.O. Box 33003
   Baltimore Maryland 21290-3003

   Exception: If using private contractor (e.g., FedEx) to mail form(s), use:

   Social Security Administration
   Division of Earnings Record Operations
   300 N. Greene St.
   Baltimore Maryland 21290-0300

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

1. Count the number of years for which you need detailed earnings information. Be sure to add in both the first and last year requested. However, do not add in the current calendar year since this information is not yet available.

2. Use the chart below to determine the correct fee.

Number of Years Requested	Fee	Number of Years Requested	Fee	Number of Years Requested	Fee
1	$15.00	15	$43.75	28	$64.50
2	17.50	16	45.50	29	66.00
3	20.00	17	47.25	30	67.50
4	22.50	18	49.00	31	68.75
5	25.00	19	50.75	32	70.00
6	27.00	20	52.50	33	71.25
7	29.00	21	54.00	34	72.50
8	31.00	22	55.50	35	73.75
9	33.00	23	57.00	36	75.00
10	35.00	24	58.50	37	76.25
11	36.75	25	60.00	38	77.50
12	38.50	26	61.50	39	78.75
13	40.25	27	63.00	40	80.00
14	42.00				

For Requests Over 40 Years, Please Add 1 Dollar for Each Additional Year.

- **Whose Earnings Can Be Requested**

1. Your Earnings

You can request earnings information from your own record by completing the attached form; we need your handwritten signature. If you sign with an "X", your mark must be witnessed by two disinterested persons who must sign their name and address.

2. Someone Else's Earnings

You can request earnings information from the record of someone else if that person tells us in writing to give the information to you. This writing or "authorization" must be presented to us within 60 days of the date it was signed by that person.

3. A Deceased Person's Earnings

You can request earnings information from the record of a deceased person if you are the legal representative of the estate, a survivor (that is, the spouse, parent, child, divorced spouse of divorced parent), or an individual with a material interest (example-financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

Proof of death must be included with your request. Proof of appointment as representative or proof of your relationship to the deceased must also be included.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit care rules will apply. You may also pay by check or money order.

We Only Accept MasterCard and Visa

Please fill in all the information below and return this form along with your request to:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore Maryland 21290-3003

Exception:
If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore Maryland 21290-0300

Note: Please read Paperwork/Privacy Act Notice

NUMBER HOLDER'S SSN → *(If more than one request, only list one SSN)*	___ ___ ___
CHECK ONE →	☐ MasterCard ☐ VISA
Credit Card Holder's Name → (Enter the name from the credit card)	First, Middle Initial, Last Name
Credit Card Holder's Address →	Number & Street City, State, Zip Code
Daytime Telephone Number →	___ ___ Area Code Telephone Number
Amount Charged $ ___	Credit Card Number ___ - ___ - ___ - ___
	Credit Card Expiration Date Month | Year
Credit Card Holder's Signature →	
DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization Name | Date

PRIVACY ACT NOTICE

The Social Security Administration (SSA) has authority to collect the information requested on this form under section 205 of the Social Security Act. Giving us this information is voluntary. You do not have to do it. We will need this information only if you choose to make payment by credit card. You do not need to fill out this form if you choose another means of payment (for example, by check or money order).

If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and SSA's account. We may also provide this information to another person or government agency to comply with federal laws requiring the release of information from our records. You can find these and other routine uses of information provided to SSA listed in the Federal Register. If you want more information about this, you may call or write any Social Security Office.

Form **4506**

(Rev. November 2005)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed. Read the instructions on page 2.**

▶ **Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.**

OMB No. 1545-0429

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T,** Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return	**2b Second social security number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

Caution: *If a third party requires you to complete Form 4506,* ***do not*** *sign Form 4506 if lines 6 and 7 are blank.*

6 **Tax return requested** (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ _____

Note. *If the copies must be certified for court or administrative proceedings, check here.* . . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

/ /	/ /	/ /	/ /
/ /	/ /	/ /	/ /

8 **Fee.** There is a $39 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.**

a	Cost for each return	$ 39.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . ☐

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

Sign Here

▶ **Signature** (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a ( )
▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)		
▶ **Spouse's** signature	Date	